RHEUMATOLOGY ASSOCIATES of SOUTH TEXAS

Kevin J. Kempf, M.D Everett H. Allen, M.D. Thomas A. Rennie, M.D.
Gautam Moorjani, M.D. Emily T. Marx, M.D. Jane B. Ayala, M.D.
19272 Stone Oak Parkway Suite 101 San Antonio, TX 78258 (210) 265-8851 Fax: (210) 265-8855
3903 Wiseman, Ste 221, San Antonio, TX 78251 (210) 448-4344 Fax: (210) 448-4347

Dear Mr. / Ms. _____,

We look forward to seeing you at your scheduled appointment. Thank you for choosing Rheumatology Associates of South Texas for your rheumatology health care needs. **Our group is composed of six Board Certified Rheumatologist who are dedicated to the diagnosis and treatment of rheumatic diseases.** We take pride in our friendly and cordial staff, and hope to make your visits with us pleasurable.

Please take the time to log onto the patient portal and confirm your information has been entered in correctly.

Stone Oak: office hours are 7:30 AM to 4:30 PM, Monday through Thursday and 7:30 AM to 1:00 PM on Friday. Each doctor's time may vary slightly.

Westover Hills: office hours are 7:00 AM to 4:00 PM, Monday through Thursday and 7:00 AM to 1:00 PM on Friday. Each doctor's time may vary slightly.

Enclosed is a new patient packet for your convenience. Please complete the packet and bring it with you on the day of your initial visit. We pay close attention to your valuable time and ask that you arrive on time for you appointment. If you are late, your appointment will be rescheduled to the next available time. You are asked to **arrive 30 minutes prior** to your scheduled time in order to be processed into our system. Your initial visit will take approximately 45 minutes. We have a Quest phlebotomist on site for your convenience. You will need to verify with your insurance that you will be eligible to utilize their services.

Please bring your current insurance card and photo identification with you. Our office requires you bring your current insurance card to every visit.

We are in network with most major insurance plans. Please verify with your insurance prior to your visit, as payment for all co-payments, deductible, and co-insurance are expected at the time of your visit. If your insurance requires a referral from your primary health care physician, it is your responsibility to either bring it with you or have it sent prior to your visit. If you do not have the referral or it is not on file, your appointment will be rescheduled.

As a courtesy to our staff and fellow patients please notify our office at least 24 hours in advance if you need to reschedule your appointment. **As an established patient, if you fail to cancel or reschedule your appointment there will be a fee of $45.00 dollars. If you cancel the same day or no show for a new patient appointment, you will be charged a $100.00 dollar fee and you will not able to re-schedule until this is paid.**

We look forward to seeing you in our office. Please visit our website at www.ra-stx.com for directions and additional information about our office.

Sincerely,
Rheumatology Associates of South Texas

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(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Preferred Language: Eng ___ Span____ Other____	Birth date: / /	Age:	Sex Assigned at Birth: ❑ M ❑ F

Email Address:	Race:	Ethnicity:
Street address:	Social Security Number:	Home Phone Number: ( )

City:	State:	Zip:	Cell phone ( )
Employer:	Employer phone number: ( )		
Referred to clinic by/Chose clinic because (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other
Other family members seen here:				
Pharmacy Name:	Pharmacy Phone Number:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No			

Please indicate primary insurance	❑ Medicare	❑ Humana HMO ❑ Humana PPO	❑ Aetna HMO ❑ POS ❑Aetna PPO	❑ Secure Horizons	❑ United Health Care
❑ PHCS	❑ Medicaid	❑ Cigna HMO ❑ POS ❑ Cigna PPO	❑ Texas True Choice	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Updated 09/16

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FINANCIAL POLICY

I, _____, hereby certify that I am eligible for health plan coverage with _____. (Your insurance name)

I understand that if the above is not true or if I am not eligible under the terms of my medical subscriber health insurance, I am liable for all charges for services rendered.

I agree to bring my current insurance card to every appointment.

I further authorize the physician (s) providing services to release for insurance purposes, any information acquired in the course of my examination and treatment.

Assignment of Insurance Benefits

In consideration of services rendered, I hereby transfer and assign all rights of payment due to me for medical and or surgical services under any policies of insurance.

Responsible Party Signature: _____ Date: _____

FINANCIAL POLICY

This is an agreement between Rheumatology Associates of South Texas, PLLC., as creditor, and the Patient/Debtor named on this form.
In this agreement the words “you”, “your”, and “yours” mean the Patient/Debtor. The word “Account” means the account that has been established in your name to which charges are made and payments are credited.
The words “we”, “us”, and “our” refer to Rheumatology Associates of South Texas, PLLC.

By executing this agreement, you are agreeing to pay for all services received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. These statements represent the balance owed after we receive the explanation of benefits from your insurance with payment or denial information.
Payments: Co-pays, co-insurance or self-pay are due at the time services are rendered. For your convenience we accept cash, check, credit cards, and money orders. Unless other arrangements are approved by our billing staff, the balance on your statement is due and payable when the statement is issued and is past due if not paid by the end of the month. If no payments on your account balance have been made within 90 days of the first statement, your account may be turned over to a collection agency. At that point your care with your physician and all physicians in this practice can be terminated.
Returned Checks: There is a fee (Currently $45.00) for any check returned by the bank.
Past Due Accounts: If your account is past due, we will take necessary steps to collect this debt. If we are unable to collect this debt you will be dismissed from our practice and we may refer your account to a collections agency, and your past due status may be reported to a credit bureau.
Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact of your treatment at our office may become a matter of public record.
Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name: _____

Patient Signature: _____ Date: _____

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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I, _____(NAME), authorize Rheumatology Associates of South Texas to release all/any information regarding my medical care or treatment including labs, imaging, appointment and billing information to the following persons(s):

NAME:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

Please list you additional healthcare providers
(ex. Cardiologist, Dr. __, Phone Number)

Specialty:	Physician Name:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

I, _____(NAME), authorize Rheumatology Associates of South Texas to contact me for all/any information regarding my medical care or treatment including labs, imaging, appointment and billing information in the following way(s):

☐ Phone Call ☐ Leave Voicemail

For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

☐ Text Communication ☐ Email: _____

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____	_____	_____
Patient Signature	Date of Birth	Date

Updated 08/21

AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

Patient History Form

Date of first appointment: ____/____/____ (MONTH / DAY / YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST / FIRST / MIDDLE INITIAL / MAIDEN) Birthdate: ____/____/____ (MONTH / DAY / YEAR)

Address: _____ (STREET / APT#) Age _____ Sex Assigned at Birth: F ☐ M ☐

_____ (CITY / STATE / ZIP) Telephone: Home: (____) _____

Work: (____) _____

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Significant Other: ☐ Alive/Age _____ ☐ Deceased/Age _____ Major Illnesses: _____

EDUCATION *(circle highest level attended):*

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/Average per work: _____

Referred here by: *(check one)* ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms: _____

_____

_____

_____

_____

Date symptoms began *(approximate)*: _____

Diagnosis: _____

Previous treatment for this problem *(include physical therapy, surgery and injections; medications to be listed later)*:

_____

_____

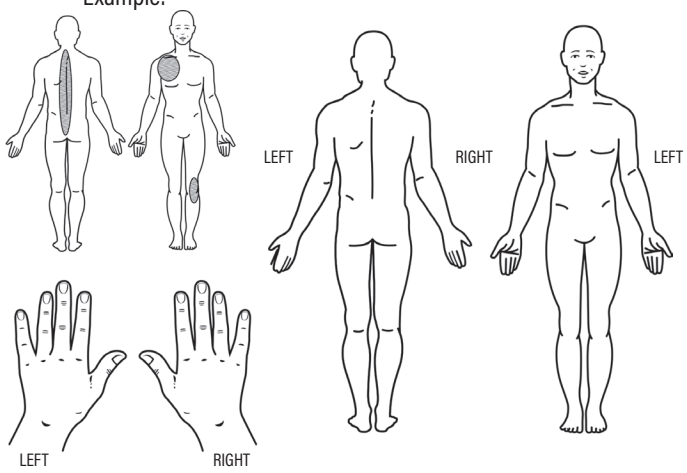
_____

Please list the names of other practitioners you have seen for this problem:

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? *(check if "yes")*

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions: _____

Patient's Name: _____ Date: _____ Physician Initials: _____

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: ____/____/____ Date of last eye exam: ____/____/____ Date of last chest x-ray: ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ☐ Recent weight gain amount _____
- ☐ Recent weight loss amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat

- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty swallowing

Cardiovascular

- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory

- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? ☐ Yes ☐ No

How many days apart? _____

Date of last period? ____/____/____

Date of last pap? ____/____/____

Bleeding after menopause? ☐ Yes ☐ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ☐ Morning stiffness

  Lasting how long?

  _____Minutes _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

  List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold

Neurological System

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric

- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine

- ☐ Excessive thirst

Hematologic/Lymphatic

- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when_____

Allergic/Immunologic

- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name: _____ Date: _____ Physician Initials: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago? _____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Has anyone ever told you to cut down on your drinking?

☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No

If yes, please list: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now have or have you ever had: *(check if "yes)*

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness *(please list)* _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ No ☐ Yes *Describe:* _____

Any other serious injuries? ☐ No ☐ Yes *Describe:* _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children _____

_____

Do you know any blood relative who has or had: (check and give relationship)

☐ Cancer _____	☐ Heart disease _____	☐ Rheumatic fever _____	☐ Tuberculosis _____
☐ Leukemia _____	☐ High blood pressure _____	☐ Epilepsy _____	☐ Diabetes _____
☐ Stroke _____	☐ Bleeding tendency _____	☐ Asthma _____	☐ Goiter _____
☐ Colitis _____	☐ Alcoholism _____	☐ Psoriasis _____	

Patient's Name: _____ Date: _____ Physician Initials: _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes If yes, please list: _____

_____

Type of reaction: _____

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

PAST MEDICATIONS: Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. *Record your comments in the spaces provided.*

Drug names/Dose	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		☐	☐	☐	
Circle any you have taken in the past Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac					
Pain Relievers					
Acetaminophen		☐	☐	☐	
Codeine		☐	☐	☐	
Propoxyphene		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		☐	☐	☐	
Golimumab		☐	☐	☐	
Hydroxychloroquine		☐	☐	☐	
Penicillamine		☐	☐	☐	
Methotrexate		☐	☐	☐	
Azathioprine		☐	☐	☐	
Sulfasalazine		☐	☐	☐	
Quinacrine		☐	☐	☐	
Cyclophosphamide		☐	☐	☐	
Cyclosporine A		☐	☐	☐	
Etanercept		☐	☐	☐	
Infliximab		☐	☐	☐	
Tocilizumab		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	

Patient's Name: _____ Date: _____ Physician Initials: _____

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen		❑	❑	❑	
Alendronate		❑	❑	❑	
Etidronate		❑	❑	❑	
Raloxifene		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal		❑	❑	❑	
Risedronate		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen		❑	❑	❑	
Tiludronate		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyaluronan		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	

Please list supplements:

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list:

Patient's Name: _____ Date: _____ Physician Initials: _____

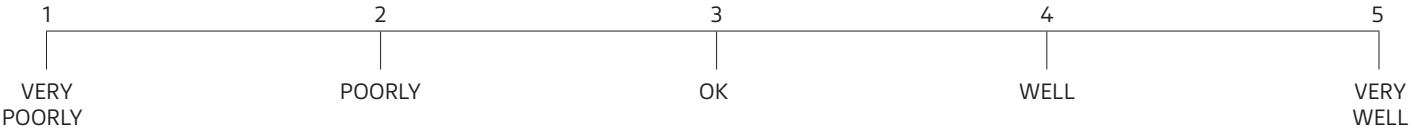
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ☐ Yes ☐ No *If yes, how many?*

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	☐	☐	☐
Walking?	☐	☐	☐
Climbing stairs?	☐	☐	☐
Descending stairs?	☐	☐	☐
Sitting down?	☐	☐	☐
Getting up from chair?	☐	☐	☐
Touching your feet while seated?	☐	☐	☐
Reaching behind your back?	☐	☐	☐
Reaching behind your head?	☐	☐	☐
Dressing yourself?	☐	☐	☐
Going to sleep?	☐	☐	☐
Staying asleep due to pain?	☐	☐	☐
Obtaining restful sleep?	☐	☐	☐
Bathing?	☐	☐	☐
Eating?	☐	☐	☐
Working?	☐	☐	☐
Getting along with family members?	☐	☐	☐
In your sexual relationship?	☐	☐	☐
Engaging in leisure time activities?	☐	☐	☐
With morning stiffness	☐	☐	☐
Do you use a cane, crutches, walker or wheelchair? *(circle one)*	☐	☐	☐

What is the hardest thing for you to do? _____

Are you receiving disability? Yes ☐ No ☐

Are you applying for disability? Yes ☐ No ☐

Do you have a medically related lawsuit pending? Yes ☐ No ☐

Patient's Name: _____ Date: _____ Physician Initials: _____

ACTIVITIES OF DAILY LIVING

****

Are you currently or were you recently in a skilled nursing facility or hospice? ☐ No ☐ Yes
If so please provide information to the facility below.

****

Skilled Nursing Facility/Hospice Information:

Start Date: _____ Leave Date: _____

Facility Name: _____

Address: _____

Phone #_____

Case Worker's Name: _____

1. Please check (✓) the **ONE** best answer for your abilities at this time:

OVER THE PAST WEEK, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
Participate in sports and games as you would like?	☐ 0	☐ 1	☐ 2	☐ 3
Get a good night's sleep?	☐ 0	☐ 1	☐ 2	☐ 3
Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1	☐ 2	☐ 3
Deal with feelings of depression or feeling blue?	☐ 0	☐ 1	☐ 2	☐ 3

2. How much pain have you had because of your condition **OVER THE PAST WEEK?** Please indicate below how severe your pain has been:

NO PAIN ○ **PAIN AS BAD AS IT COULD BE**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

3. Considering all the ways in which illness and health conditions may affect you at this time, please Indicate below how you are doing:

VERY WELL ○ **VERY POORLY**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

FN (1) ☐

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

PN (2) ☐

PTGL (3) ☐

RAPID ☐

(0-30)

Category
HS=>12
MS=6.1-12
LS= 3.1-6
R= ≤3